Rhode Island AIDS Drug Assistance Program
Financial Enrollment Form

Do not write in this box		Insurance

Please answer <u>all</u> questions and <u>sign</u> this form.
Please print clearly. ***Failure to complete all information may delay the application process.***

A <u>Medical Enrollment Form</u> must also be completed by your medical provider and submitted with this form.

1. **Name:** _____
   Last First MI
2. **Address:** _____
   Street City State Zip
3. **Telephone:** (_ _ _) _ _ _ - _ _ _ _ **4. Social Security #:** _ _ _ / _ _ / _ _ _ _
5. **Date of Birth:** _ _ / _ _ /_ _ **6. Gender:** □ Male □ Female □ Transgender
7. **Sexual Orientation:** □ Gay Man □ Lesbian □ Heterosexual □ Bisexual □ Other
8. **Number of Family Members Living in Your Household (including yourself):** _____
9. **Race / Ethnicity:**
   □ Black/African American (**not Hispanic**) □ White (**not Hispanic**) □ Hispanic/Latino(a)
   □ Native American/Indian (**not Hispanic**) □ Asian □ Other
   □ More than one race
11. **Are you aware of how you contracted HIV?**
    □ Male/male sex □ IV drug use □ Heterosexual relations □ Do not know □ Other _____
12. **What is your <u>family household's average monthly</u> income? $_____ Please attach proof of income (e.g. copy(ies) of pay stub(s), social security, GPA check, etc.)**
13. **Do you have any of the following:**

MEDICAID/Medical Assistance □ Yes ID/Card Number _____ □ No

RIte Care □ Yes ID/Card Number _____ □ No

Medicare □ Yes ID/Card Number _____ □ No

GPA □ Yes ID/Card number _____ □ No
Other Public Assistance (please specify) _____

<u>Private</u> Medical Insurance □ Yes ID/Policy Number_____ □ No
What type of insurance (e.g. Blue Cross, United, etc.)? _____

14. Have you applied for Medicare? □ Yes; Date applied _____ □ No

15. Have you applied for Medicaid? □ Yes; Date applied _____ □ No

Other Public Assistance? (specify) _____ □ Yes; Date: _____ □ No

If yes, to any of the above, please attach a copy of your application or indicate date applied (above).

16. Is AIDS Project RI helping you with COBRA/Health Insurance payments? □ Yes □ No

17. Do you currently have an HIV case manager? □ Yes; What agency?_____ □ No

18. Do you have a case manager with another agency? If so, which agency? _____ □ No

19. Housing: □ Permanent (Rent or Own) □ Non Permanent (e.g., shelter, treatment program)

20. Are you employed now? □ Yes □ No **17. Job Description:** _____

21. Employer Name and Address: _____

22. Are you a military service veteran? □ Yes □ No

If yes, have you sought treatment or services through the VA?

□ Yes; ID/Card number _____ □ No

This form should be mailed or faxed to:

The RIAID Program,
Rhode Island Department of Health
Office of HIV and AIDS
3 Capitol Hill, Room 106
Providence, RI 02908
Tel: 401-222-7548
Fax: 401-222-6001
www.health.ri.gov

I certify that the information provided in this application is true and correct as of the date set forth below and acknowledge that any intentional or negligent misrepresentation of the information may result in nullification of this application and liability for money granted.

Signature _____ Date____ _____

Please provide name of pharmacy AND phone number. Without this information we cannot contact your pharmacy to enroll you in the program.

Pharmacy _____ _____ _____
Store Name Address Phone

Rhode Island AIDS Drug Assistance Program
Medical Enrollment Form

Client Code: (Do NOT fill in): ☐

To Be Completed by Medical Provider

Please print clearly and fill in ALL information.

Client Name _____, _____ **DOB:** _ _ /_ _ /_ _
Last First MI month day year

HIV antibody test positive since (or approximate date of first positive HIV test) _____

AIDS Diagnosis ☐ **Yes Date** ___/___/___ ☐ **No**

HCV Test ☐ **Yes Date** ___/___/___ ☐ **Negative** ☐ **Positive** ☐ **Not tested/unknown**

PLEASE COMPLETE ALL INFORMATION BELOW

CD 4 count	**Count** _____ **Date of last test** ____/____/____
Viral Load (most recent)	**Count** _____ **Date:** ____/____/____ **Type of test** _____ **(bDNA, RT-PCR)**
Drug Therapy	☐ **No HAART medications** ☐ _____ **Antiretrovirals currently** ***(insert number)*** ☐ **HCV therapy**

Name of Physician (print) _____ **RI Lic. #** _____

Signature of Physician _____ **Date** ____/____/____

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